

## Non Carious Cervical Lesions

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Non-Carious-Tooth-Wear//Attrition,-Abrasion,-Abfraction,-Erosion//Clinical-Appearance,-Diagnosis Air-abrsion-in-Non-carious-cervical-lesion **Fifth class Black NCCL Non Caries Cervical Lesions Composite Fillin Restoration No Rubberdam Oral Radiology | Radiographic Interpretation | NBDE Part II** Practice Inspiration TOP TEN — Dr. Giovanni Zucchelli — Non Carious Cervical Lesions*How to Restore Non-Carious Lesions: Dental Technique Non-Carious Cervical Lesions.flv* Operative Dentistry | Diagnosis-#0026-Treatment-Planning | NBDE Part II Treatment Of Non-Carious Lesions: Dr. Mustafa Abbas Non carious cervical lesion DrKim non carious cervical lesions 3 *Non carious cervical lesions (NCCLs) and gingival recession - Dr. Simone Deliperi Caries removal with Brix 3000 enzymatic gel. Class V composite with audio How To Restore Multiple Class V Abfractions Bonding Tooth Brush Abrasion Repair Composite resin Class V restoration Dental Erosion 04-Abfraction.flv* Do you suffer from tooth wear in Toronto Ontario **What to do when a tooth has a deep carious lesion Abfraction | Lake Merritt Dental, Oakland, CA Non carious cervical lesions part 1 Preview N C C L What I know about the Non Carious Cervical Lesions Non carious cervical lesions part 2** NON-CARIOUS CERVICAL LESIONS/WASTING DISEASE OF THE TEETH/ EROSION/ABRASION/ABFRACTION Tooth Attrition-Non carious lesion of tooth Restoration of Noncarious Cervical Lesions *Bioclear Matrix | Chapter 4: Moderately Deep Caries With Selective Caries Removal Pediatric Dentistry | Pediatric Soft Tissue | NDBE Part II* Non Carious Cervical Lesions Non-carious cervical lesions (NCCLs) are defined as dental tissue lost at or near the cementoenamel junction (CEJ), and not relating to tooth decay. NCCLs are common in the dentitions of recent human populations. They may result from several processes including abrasion, acid erosion and abfraction.

Non-carious cervical lesions - Wikipedia Noncarious cervical lesions (NCCLs) involve the loss of hard tissue from the cervical areas of teeth through processes unrelated to caries. NCCLs are nowadays a common pathology caused by changes in lifestyle and diet. The prevalence and severity of cervical wear increase with age. It is generally accepted that the lesions are not generated by a single factor but result from a combination of factors.

Treatment of noncarious cervical lesions: when, why, and how The etiology of non-carious cervical lesions (NCCLs) is a combined, or more commonly, a multifactorial condition. There are three mechanisms that contribute to the etiology of NCCLs: stress, friction, and bio-corrosion. The effects of stress manifested as abfraction and occurs through the dynamics of both static and cyclic occlusal loading.

Non-Carious Cervical Lesions | Inside Dentistry In an initial clinical examination, 140 cases were selected that presented one or more teeth with non-carious cervical wear. For each case, a similar sex and age control without any tooth with non-carious cervical lesions was selected. An occlusal examination and periodontal probing were performed in all cases and controls by skilled dentists.

Non-carious cervical lesions and risk factors: A case ... Non-carious cervical lesions (NCCL) are characterized by a loss of hard dental tissue near the cement-enamel-junction. Commonly, their shape is like a wedge with the apex pointing inwards. Other times, they appear as regular depressions, like a dome or a cup. Their main characteristic is the presence of hard-mineralized tissue.

Non carious cervical lesions. A review Non-carious cervical lesions (NCCL) are characterized by a loss of hard dental tissue near the cement-enamel-junction. Commonly, their shape is like a wedge with the apex pointing inwards. Other...

(PDF) Non carious cervical lesions. A review estimated, role in the etiology of non-carious cervical lesions. The very nature of non-carious cervical lesions makes them difficult to study, because what causes the lesions to initially form may or may not be what results in their progression. By the time the lesion is formed, the "smoking gun" may be long gone. As most research reveals, the etiology and progression of non-carious cervical lesions

\*\*\*Handout\*\*\* Non-Carious Cervical Lesions: Causes ... A noncarious cervical lesion (NCCL) is a small saucer- or notch-shaped loss of tooth structure at the cementoenamel junction that is most commonly found on the tooth’s facial surface (Figure 1). These lesions are not at increased risk of caries because they are generally accessible for self and professional cleaning.

Treatment Strategies for Noncarious Cervical Lesions ...

- Currently it is a accepted that non-carious cervical lesion have a multifactorial etiology and are not related to any one factor. A combination of erosion, abrasion and abfraction may operate in the initiation and progression of these lesions. 9.

Non carious cervical lesion - SlideShare Non-carious cervical lesions (NCCL), defined as loss of dental tissue in absence of bacterial aggression, have a multifactorial etiology, implying abrasion, abfraction and acid erosion, acting ...

(PDF) Treatment of non-carious lesions: Diagnosis ... Clinical presentation of abfraction non-carious tooth tissue lesions on the cervical margins of upper left canine and premolar Abfraction is a theoretical concept explaining a loss of tooth structure not caused by tooth decay (non-carious cervical lesions).

Abfraction - Wikipedia At this time, restoration of noncarious cervical lesions (NCCLs) is a common occurrence in clinics nowadays. Some reasons for this are the growth of the elderly population, a smaller rate of tooth loss, and possibly the increase of some etiologic factors.

Restoration of Noncarious Cervical Lesions: When, Why, and How Noncarious cervical lesions (NCCLs) are defined as a loss of hard dental tissue near the cementoenamel junction, usually on the buccal surfaces of teeth, resulting in a grooved or wedge-shaped area of missing tooth structure.

Managing Noncarious Cervical Lesions - Decisions in Dentistry Erosion and abrasion have been widely reported as causes of non-carious cervical lesions (NCCL). However, more recently, tooth flexure has been implicated in the formation of these lesions generating renewed interest in the pathogenesis of the non-carious loss of cervical tooth substance.

The aetiology of the non-carious cervical lesion - Osborne ... The term noncarious cervical lesion (NCCL) refers to the loss of tooth structure at the cementoenamel junction - (CEJ) and subjacent root surface of the teeth by wear processes unrelated to bacterial action. The lesions can be located on the vestibular, oral, or approximal side of the tooth.

Noncarious Cervical Lesions: Correlation between ... Noncarious Cervical Lesions and Cervical Dentin Hypersensitivity: Etiology, Diagnosis, and Treatment

(PDF) Noncarious Cervical Lesions and Cervical Dentin ... CLINICAL MANAGEMENT OF NON-CARIOUS CERVICAL LESIONSNon-carvious cervical lesions require clinical attention if any of the following factors exist:1. Tooth sensitivity- Exposure of dentin in the cervical area may result in dentin hypersensitivity.2.

Non carious lesion - SlideShare The durability in non-carious cervical lesions of the HEMA-free adhesives was successful after 5 years. Despite concerns which have been raised, showed the 1-step SEA one of the best reported clinical dentin bonding effectiveness.

A randomized controlled 5-year prospective study of two ... Introduction Abfraction is a theoretical term used that has been classified as a type of non-carious cervical lesion (NCCL) and characterised by the microstructural loss of hard dental tissue in areas of high stress concentration.

Non-carious cervical lesions are commonly encountered in clinical practice and present in a variety of forms. The topic of interest deals with the treatment aspect of non carious lesions like attrition, abrasion, erosion; their respective classifications; etiologies; clinical presentations and their prevention.It gives an insight into the clinical understanding of these non carious cervical lesions.A knowledge of the aetiology of these lesions is important for preventing further lesions, halting progression of lesions already present, and determining appropriate treatment.

ABSTRACT: The finding that only modern skulls displayed NCCLs may be explained by toothbrush use and/or acid erosion. Conversely, the ancient skulls may have incorporated more abrasive substances into their diet and may not have had an average lifespan long enough to develop NCCLs. Regardless, both collections included many skulls, which showed heavy occlusal wear but failed to show any NCCLs. From the results of this study it can be suggested that occlusal wear, likely derived from heavy occlusal forces, is not associated with the presence of non-carious cervical lesions. So-called abfraction lesions likely have a multifactorial etiology, rather than an origin in occlusal stress.

Non-carious cervical lesions (NCCLs) have a non-bacterial origin and produce a loss of tooth structure at the cemento-enamel junction. A review of the literature reveals that these lesions may have a multifactorial etiology (chemical, abrasion, abfraction). The role of heavy biting forces in the pathogenesis of NCCLs is yet to be firmly established. Treatment and preventive measures for NCCLs can be improved if the etiology can be clearly identified and treated. Objective: This prospective clinical trial measured the volume loss (increase in size) of NCCLs and the occlusal biting forces applied to these teeth; diet and toothbrushing analysis, followed by a comprehensive mounted cast occlusal analysis to determine which factors were significant in the progression of these lesions. Materials and Methods: Patients with non-carious cervical lesions were screened and consent obtained. Digital images and poly vinyl siloxane impressions (Aquasil Ultra/Dentsply, USA) were made, casts poured (Fujirock Type IV Die & model stone/ GC America). To measure the NCCL depth and volume, casts were scanned using Proscan 2000 Non Contact Profilometer, and the scans were superimposed over the baseline scans with the Proform software to measure the change in NCCLs over a five-year period. T-scan and Fujifilm Pre-scale films (analyzed by Topaq Occlusal Analysis System) were used to record the relative and absolute biting forces on teeth with NCCL. Lesion progression from baseline to five years was correlated to absolute occlusal force using regression analysis and KS test for normality. One way ANOVA compared lesion progression with toothbrushing technique and presence of adverse oral habits like nail biting; while Mann-Whitney test was used to correlate NCCL progression with the diet score. Results: Rate of progression is related to mean bite force (p=0.01), presence of adverse oral habits (p=0.02) and consumption of a more acidic diet (p=0.04); but not associated significantly with occlusal wear facets, group function or toothbrushing technique. Conclusions: Within the limitations of this study, it may be concluded that heavy biting forces, erosive diet and adverse oral habits play a significant role in the progression of NCCLs over time.

This handbook distils the most up-to-date theory and practical information on dental erosion and dentin hypersensitivity into an accessible and practical clinical guide for general dental practitioners, dental students, dental educators, and other health professionals. Topics are covered in a step-by-step, easy-to-understand manner, with tables, checklists, images, flowcharts, and bullet point-like presentation of core messages that is ideal for busy dental practitioners and students. Besides providing evidence-based guidance on treatment and prevention strategies, the book examines thoroughly the dental erosion process itself and the intrinsic and extrinsic causes. Chapters are also included on the etiology, prevalence, and management of dentin hypersensitivity, the restoration of worn dentin, and non-carious cervical lesions. The authors are renowned, clinically active international experts in different aspects of dental erosion and its management.

Erosive tooth wear is a multifactorial condition of growing concern to the clinician and is a subject of extensive research. This book is the first which deals in such detail with dental erosion. It presents the whole spectrum of views on the issue, from the molecular level to behavioral aspects, as well as trends in society. The multifactorial etiological pattern of erosive tooth wear is emphasized and is a strand connecting the different chapters of the book. Definition, diagnosis, prevalence, incidence and chemistry of dental erosion are discussed in the first part of the publication. Further, topics like extrinsic and intrinsic causes of dental erosion are covered and a chapter is devoted to dental erosion in children. Methods of assessment are presented and critically evaluated. The book concludes with themes on dentinal hypersensitivity, risk assessment and preventive measures and restorative options for erosive lesions. This publication is not only highly recommended to faculty members, researchers and dental students, but also to practitioners and other dental professionals who are committed to the prevention and treatment of dental erosion.

The “total-etch” or “etch-and-rinse” systems have been the gold standard of dental bonding for decades. However, these systems are very technique-sensitive and time-consuming compared to newer “self-etch” or “self-adhesive” systems and have been implicated in cases of postoperative sensitivity. The purpose of this study was to compare the effects of two surface treatment protocols (self-etch vs. selective-etch) on the clinical performance of a universal adhesive and resin composite in Class V non-carious cervical lesions (NCCLs). Thirty-three volunteer subjects (17 male; 16 female; age range = 20 to 75 years) having at least two NCCLs were selected from patients of record at Indiana University School of Dentistry. Each subject received one resin composite restoration (Tetric EvoCeram, Ivoclar Vivadent) utilizing a self-etch (SfE) universal adhesive (Adhese Universal, Ivoclar Vivadent) with no separate enamel etching and another restoration utilizing adhesive and selective enamel etching (SeIE) with 37% phosphoric acid (H3PO4). Both the adhesive and composite were placed following the manufacturer’s instructions. The two techniques were compared for differences in sensitivity, retention, marginal discoloration, marginal adaptation, and clinical acceptability at baseline and 6 months using the Cochran-Mantel-Haenszel tests for stratified, ordered categorical outcomes. Seventy-four restorations (37 SfE, 37 SeIE) in 30 volunteers were evaluated at 12 months. No significant differences were found between the SfE and SeIE groups for any variable at the 12-month recall (p>0.21). Retention was 100% at 12 months for both groups. Marginal adaptation was significantly worse at 12 months than at baseline for SeIE (p=0.0163), but there was no difference for SfE (p=0.08). Sensitivity improved significantly from baseline to 12 months for both SeIE (p=0.0113) and SfE (p=0.0128). The results obtained from this study are comparable to results observed in similar studies. Like similar studies involving self-etch adhesives in non-carious cervical lesions, our study showed no restorations lost to caries and excellent retention. The deterioration of selective-etch dentin margins was a result that differed from similar studies. A likely explanation for this finding would be the difficulty of controlling precise placement of phosphoric acid gel, causing undesired etching of dentin; this could result in suboptimal bonding to dentin. This report on 12-month data for a two-year study indicates significantly reduced sensitivity for both the SeIE and SfE groups, and deterioration of SeIE marginal adaptation. No decreases in retention, marginal discoloration, or clinical acceptability were observed in either group.

